Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: THE CLINIC FOR SPECIAL SURGERY 900 12TH AVENUE FORT WORTH TX 76104	MFDR Tracking #: M4-04-3781-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: INSURANCE CO OF THE STATE OF PA Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Not paid at usual and customary as ordered 6/18/03 when final judgment was entered in cause GN202229 in District Court of Travis County, 98th Judicial District. Preauthorization was given –see attached pre-auth letter."

Requestor's request for reconsideration states "Our billing reflects customary, fair and reasonable fees for the services rendered this patient as evidenced by…Acceptance of the reasonable of our fees by is widespread among different insurers: Federal workman's compensation reimbursement is 100%…Texas Workers Compensation averages reimbursement of 84%..."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $7,539.30

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Requestor has failed to properly submit a request for IRO. The surgery the subject of this dispute was originally preauthorized by HDI on September 19, 2002. However, Dr. Dillen was notified by telephone on November 12, 2002, that Dr. Kern had, by report dated November 6, 2002, found that with the passage of time without performing the surgery and other factors, the proposed surgery to then be medically unnecessary. (Exhibit A). That report was faxed to Drs. Dillen and Brooks on November 12, 2002. I spite of the knowledge of this medical necessity dispute, Dr. Dillen chose to perform the surgery anyway on November 20, 2002." "Requestor has performed surgery without a concurrent authorization to do so and neither the MRD nor SOAH has authority to order payment for the services. See SOAH Decision No. 453-99-0227.M2." "The billing in dispute must be paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/20/2002	F,V	29820	$7,539.30	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 19, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 1, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - V-Unnecessary medical treatment and or service per peer review; documentation attached.
   - F-Recommendation of payment has been based on this procedure code, Y4900 which best describes services rendered.
2. Division rule at 28 TAC §134.600(b)(1)(B), effective January 1, 2002, 26 TexReg 9874, states "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care."
3. Division rule at 28 TAC §134.600(e)(2)(A) and (B), effective January 1, 2002, 26 TexReg 9874, states "The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (h) of this section…(2) include: (A) the specific health care listed in subsection (h) or (i) of this section; (B) the number of specific health care treatments and/or the specific period of time requested."
4. Division rule at 28 TAC §134.600(f)(1), effective January 1, 2002, 26 TexReg 9874, states "The carrier shall: (1) approve or deny requests for preauthorization or concurrent review based solely upon the reasonable and necessary medical health care required to treat the injury…" The Division finds that on September 19, 2002 the requestor obtained preauthorization for outpatient surgery for left shoulder arthroscopy with AC resection. The report lists a begin date of 10/09/2002 and expiration date of 11/23/2002. Therefore, the insurance carrier's denial of unnecessary medical treatment is not supported per Division rule at 28 TAC §134.600(f)(1).
5. Division rule at 28 TAC §134.600(h)(2), effective January 1, 2002, 26 TexReg 9874, requires preauthorization for non-emergency healthcare which includes "(2) outpatient surgical or ambulatory surgical services, as defined in subsection (a) of this section." The Division finds that on September 19, 2002 the requestor obtained preauthorization for outpatient surgery for left shoulder arthroscopy with AC resection. Therefore, the requestor obtained preauthorization for the disputed service per Division rule at 28 TAC §134.600(h)(2).
6. The Division issued Advisory 2001-03, titled Preauthorization Process and Access to Medical Dispute Resolution on February 22, 2001 that states "Approval: If the decision is an approval (Yes), the IC/URA must notify the TD or TDs Rep by telephone or fax. This approval establishes liability for payment of the preauthorized care…Preauthorization approval process ends here. Once the IC/URA has approved the medical necessity for a specific treatment or service, the IC may not retrospectively deny payment based on medical necessity, but may retroactively dispute the amount of reimbursement."
7. Division rule at 28 TAC §133.301(a), effective July 15, 2000, states "The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title…" After preauthorization was given, the respondent states in the position summary that "…Dr. Dillen was notified by telephone on November 12, 2002, that Dr. Kern had, by report dated November 6, 2002, found that with the passage of time without performing the surgery and other factors, the proposed surgery to then be medically unnecessary." The disputed date of service was within the period given on the preauthorization approval report. The Division finds that the insurance carrier's denial of "V" is not in accordance with Division rule at 28 TAC §133.301(a).
8. Division rule at 28 TAC §134.401(a)(4), effective August 1, 1997, states "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements."
9. This dispute relates to ambulatory surgical care services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
10. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and

paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

11. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division reviewed the *Table of Disputed Services* and finds that the requestor listed CPT codes 29820 and 23480-51 on the table. For CPT code 23480-51, the requestor did not list the disputed date of service, amount billed, Medical Fee Guideline MAR, total amount paid and amount in dispute. The Division concludes that this service is not in dispute because a disputed amount is not listed. The Division further concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(C).

12. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).

13. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
    - Requestor's request for reconsideration states "Our billing reflects customary, fair and reasonable fees for the services rendered this patient as evidenced by…Acceptance of the reasonable of our fees by is widespread among different insurers: Federal workman's compensation reimbursement is 100%…Texas Workers Compensation averages reimbursement of 84%..."
    - In support of the requested reimbursement, the requestor submitted three redacted medical bills and corresponding EOBs for services that are similar to the services in dispute that support payment of 100% of the billed charges. The requestor did not submit any redacted EOBs that support 84% of billed charges for Texas Workers Compensation claims. The requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOBs, was typical for the services in dispute.
    - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
    - Moreover, a reimbursement methodology based on hospital costs does not, in itself, produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

> "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models" … "are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs." … "Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective e medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."

Additionally, the Division found that a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the same fee guideline adoption preamble as above which states at 22 Texas Register 6276 (July 4, 1997) that:

> "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an

equivalent standard of living."

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

14. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.1, §133.307, §134.1, §134.401, §134.600, §133.301
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		9/9/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
		9/9/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.